POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement/Quality Management	**DOCUMENT NAME:** Peer Review Committee and Process
PAGE: 1 of 6	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED DATE:** 09/20, 7/22
PRODUCTS: Medicare/Medicaid	**REFERENCE NUMBER:** LA.QI.19

SCOPE:
Louisiana Healthcare Connections and Plan Quality Improvement/Quality Management (QI/QM) Departments.

PURPOSE:
The purpose of this policy is to identify a peer review process to evaluate the quality of care provided to a member when there is a significant potential for an adverse event, or a significant, severe adverse outcome has occurred.

POLICY:
For quality of care cases where an investigation indicates the potential for a significant adverse outcome or a significant, severe adverse event has occurred, the Plan utilizes a peer review process to evaluate the case and make recommendations for corrective action. The Peer Review Committee (PRC) is an ad-hoc subcommittee of the Quality Committee comprised of practitioners of same or similar specialty as the practitioner and/or issue under review. The PRC is responsible for reviewing alleged inappropriate or aberrant services by a practitioner including adverse events, potential quality of care issues and Provider Preventable Conditions. The Chief Medical Director may, at his/her discretion, refer other cases and/or practitioner reviews to the PRC for evaluation and corrective action recommendation.

PROCEDURE:

I. Committee

A. The Plan PRC is an ad-hoc subcommittee of the Quality Committee and includes representation from the following:
1. **Chief Medical Director and/or Medical Director**
2. **VP/Director QI/QM Department**
3. **Three (3) or more network practitioners who are peers of the practitioner being reviewed and who represent a range of specialties to include at least one practitioner with same or similar specialty as the case under review but whose presence does not indicate a conflict of interest.**
   a) **The network practitioners serving on this committee may or may not be the same external practitioners serving on the Plan Quality Committee or Credentialing Committee. If the same practitioners are used, the Quality and/or Credentialing meeting will be adjourned and the PRC meeting starts as an independent meeting with independent agenda and minutes. The Chief Medical Director/Medical Director and QI/QM designee(s) are the only Plan staff to attend the PRC**

meeting. The Plan Pharmacist may attend per specifics of the case, e.g. for concerns regarding prescribing practices.

b) Credentialing Committee members involved in the PRC's recommendation recuse themselves from the Credentialing Committee meeting when the PRC's recommendation is discussed.

c) Network practitioners are not standing members of the committee and their attendance may change based on type of case under review. Practitioners on the committee are considered consultants for the Plan and complete the applicable Physician Consultant Agreement, which includes a confidentiality agreement.

B. At least two (2) network practitioners and one (1) Plan practitioner must be present to represent a quorum.

C. The Committee is chaired by the Chief Medical Director and/or Medical Director as designated by the Chief Medical Director.

II. Peer Review Process

A. All cases with Severity Level High (3) or Critical (4) are referred to the Peer Review Committee for evaluation and action, per policy LA.QI.17 *Potential Quality of Care Incidents*. However, the Peer Review process exists outside of the Quality of Care (QOC) investigation and process, regardless of whether the QOC recommendation was a referral to the PRC.

B. As determined by the Plan PRC Chair, appropriate members of the PRC are notified in writing of the date, time and location of a committee meeting. Committee members are given at least two (2) weeks' notice to accommodate schedules.

C. For each case to be reviewed, the PRC Chair determines the appropriate specialist to serve as the lead reviewer for the case.

D. The QI/QM designee prepares the information relevant to the review(s) in question by making copies of medical records, Plan internal notes, and reports of Medical Director and other Plan staff interactions with the practitioner. Information is redacted for all identifying data such as demographic information and protected health information (PHI).

1. **From this point forward, the case is referred to by the initials of the member or an internally specified case code.**
2. **All peer review proceedings are protected by statute from discovery in any legal proceeding. Any correspondence pertaining to a peer review is labeled "Privileged and Confidential, Peer Review" thus maintaining the protection under applicable State and Federal laws.**

E. The QI/QM designee completes an agenda for the meeting and writes a short synopsis of each case for review by the committee. The case synopsis includes notation regarding presence of any past incidents and issues related to the practitioner or facility under review.

F. One week prior to the meeting, PRC packets are sent via secure delivery method (e.g. certified mail, secure email, etc.) to the committee members, including the meeting agenda, minutes from previous meetings, copies of correspondence related to old business that was sent or received since the last meeting, synopsis of case(s) to be reviewed and any other pertinent information. The lead reviewer for each case also receives a blinded copy of all relevant medical record/case information for review prior to the meeting.

G. On the date of the meeting, the PRC Chair presents an updated agenda and any additional material to each committee member, as needed.

H. The PRC Chair leads the meeting and introduces the lead reviewer for each case.

I. The lead reviewer, having reviewed the entire case prior to the meeting, gives a verbal clinical summation of the case and highlights any points of concern or discussion for the committee.

J. The PRC discusses the case and comes to a consensus on a recommended final quality of care severity level and corrective action (per Severity Level Attachment in policy LA.QI.17 *Potential Quality of Care Incidents*). The PRC uses clinical judgment in assessing the appropriateness of clinical care and determining a corrective action plan best suited the particular practitioner's situation. Questions to be considered during the review may include but are not limited to:

- **Does the case represent a deviation from the standard of care for this patient population?**
- **Does this case represent a difficulty with judgment/decision making?**

- **Does a clinical process need to be improved?**
- **Could this incident have been readily prevented?**
- **Is there an educational opportunity?**
- **Was the management/documentation of the case a problem after the complication?**
- **Is this case a potential risk management issue/liability?**

K. If the PRC requires additional information prior to making a determination, the case is pended and information is obtained and presented to the PRC at a future meeting.

L. The QI/QM designee is the committee recorder of the meeting and assures necessary documents are available for the meeting, facilitates the attendee sign-in sheet, and records minutes of the meeting.

III. Corrective Action and Follow-Up

A. Within 15 calendar days of the PRC meeting, the QI/QM designee sends a written notification via certified mail to the practitioner, as dictated by the PRC, of the meeting occurrence and outcome of the review including corrective action and timeframe for completion, if indicated. The letter is signed by the PRC Chair and/or Medical Director as appropriate.

B. The corrective actions and follow-up activities are assigned to appropriate individuals(s)/department(s) by the PRC Chair or designee. Updates on corrective actions and follow-up activities are presented to the PRC at the next meeting or other specified intervals as indicated.

C. Upon completion of the corrective actions and satisfactory behavioral changes by the practitioner, the relationship between the Plan and the practitioner are normalized. The process of normalization does not preclude the potential of continued Plan monitoring of practitioner activity. The practitioner is notified of the completion in writing, via certified mail, by the Medical Director or designee.

D. Practitioners are required to implement the suggested corrective action designated by the PRC, per their provider agreement. If the practitioner does not cooperate, network status restriction may be recommended to the Credentialing Committee, unless State or the provider contractual agreement notes otherwise.

E. If the PRC review results in a recommendation for any network status restriction, suspension or termination of the practitioner, the recommendation is presented to the Credentialing Committee and/or the Plan Board of Directors for final determination.

F. The practitioner has the right to appeal restriction, suspension or termination decisions.

G. Reviews resulting in the restriction, suspension or termination of a practitioner's participation are reported to the National Practitioners Data Bank (NPDB).

IV. Peer Review Documentation

A. Complete documentation of all peer review activities is maintained in QI/QM Department files and is reviewed at a minimum of every six (6) months for trends and repeat occurrences. This information is incorporated into re-credentialing and other quality improvement processes as appropriate. Aggregate reporting of peer review activities is reported to the Quality Assessment and Performance Improvement Committee at least semi-annually or as designated by the Plan.

B. All peer review documentation is held in strict confidence in accordance with all relevant Federal Peer Review Laws and regulations.

C. All Plan staff and PRC members are required to maintain confidentiality regarding discussion of peer review matters.

REFERENCES:
LA.QI.17-Potential Quality of Care Incidents-includes Severity Level Attachment
NCQA Health Plan Standards and Guidelines

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

REVISION	DATE
Converted corporate to local policy.	09/20
No Revisions	07/22

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a signature.